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ABSTRACT

An etiological analysis of the inverse relationship between social class and mental impairment is presented. The empirical analysis failed to support the hypothesis that within a social class disadvantaged ethnic groups have higher rates of mental impairment than advantaged ethnic groups. In general there was no difference between the rates for advantaged and disadvantaged ethnic groups. Further, this finding was not altered when the conditions of social class, age, sex, marital status, and self-reported physical health were controlled. A secondary analysis is presented which indicates that normative strain as an objectively defined condition of the social system may not directly affect mental impairment rates. The theoretical and methodological implications of objectively vs. subjectively defined normative strain are discussed. It is suggested that future research explore the differential predictive power of both objectively and subjectively defined normative strain relative to rates of deviance. (Author)

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A COMPARISON OF THE RATES OF MENTAL IMPAIRMENT FOR ADVANTAGED AND DISADVANTAGED ETHNIC GROUPS

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ABSTRACT: An etiological analysis of the inverse relationship between social class and mental impairment is presented. Sociological theory stemming from Durkheim and Merton suggests that within a given social class, disadvantaged ethnic groups (i.e., those with less opportunity for upward social mobility) experience greater normative strain due to the incompatability between the cultural goal of upward social mobility and the institutionalized means of attaining that goal. Mental impairment, as one form of deviance, is conceptualized as a mode of adaptation to such normative inconsistency. The empirical analysis failed to support the hypothesis that within a social class disadvantaged ethnic groups have higher rates of mental impairment than advantaged ethnic groups. In general there was no difference between the rates for advantaged and disadvantaged ethnic groups. Further this finding was not altered when the conditions of social class, age, sex, marital status, and self-reported physical health were controlled. A secondary analysis is presented which indicates that normative strain as an objectively defined condition of the social system may not directly affect mental impairment rates. Earlier studies suggest that there is no difference between advantaged and disadvantaged ethnic groups in regard to self-perceived discrepencies between present position and ideal future positions. The theoretical and methodological implications of objectively vs. subjectively defined normative strain are discussed. It is suggested that future research explore the differential predictive power of both objectively and subjectively defined normative strain relative to rates of deviance.

Epidemiological analyses of mental impairment rates have consistently demonstrated that the lowest social classes have the highest rates of mental impairment (e.g., Dunham, 1965; Faris and Dunham, 1939; Gurin et al, 1960; Hollingshead and Redlich, 1958; Kornhauser, 1965; Leighton et al, 1963; Malzberg, 1940, 1956; Srole et al, 1962). As a group epidemiological studies suffer from several methodological defects, both in research design and in measurement of the critical variables. Yet, because of the diversity of research techniques that have been used, some (e.g., Dohrenwend and Dohrenwend, 1969; Roman and Trice, 1967) have concluded that the consistency of findings is not simply a reflection of methodological deficiencies. Collectively, these study results suggest that there is a true inverse relationship

between social class and psychological disorder.

While most who have conducted research in this area agree that social class and mental impairment are inversely related, there is no consensus regarding the etiological interpretation. Two primary explanations are posited in the literature: the social drift hypothesis and the social causation hypothesis. For example, Myerson (1940) suggested that the concentration of schizophrenic cases in the lower social class areas could be attributed to social drift. That is, he assumed that bio-genetic defects which produce mental impairment occur randomly across class levels; however, mental impairment reduces one's ability to cope with the demands of middle and upper class life, and consequently mentally impaired individuals drift into the lower social class areas where the demands are not as rigorous and their inability to cope not as obvious. Additionally, the rates of mental impairment in the lower social classes are magnified by the concentration of bio-genetic defects resulting from prior social drift to that class level. In contrast, social causationists such as Hollingshead and Redlich (1958) suggest that the quality of life experienced by persons in lower social classes results in stress upon their psychological system. They view mental impairment as a means of coping with such stress. Thus, the noxious environment is the critical variable used to explain the higher rates of mental illness within the lower social classes.

THEORETICAL CONSIDERATIONS

The Social Drift Hypothesis: The social drift hypothesis was derived initially from the medical model of mental illness (Milton and Whaler, 1969; Page, 1971; Sarbin, 1969) which is based on an assumed link between organic malfunctioning and disordered behavior. Advocates of this perspective contended that some aspect of the physiological system which is malfunctioning produces the bizarre behavior which is in turn labeled mental illness. Increasingly, however, the emphasis has shifted from physical malfunction to personality malfunction (see Alexander and Selesnick, 1966; Roback, 1961; and Szasz, 1970 for a more detailed discussion of this transition). Although the independent variable is different, the locus of causation remains unchanged. The model from which the social drift hypothesis is derived posits an underlying malfunction, either physical or psychological, which is responsible for the behavior patterns labeled as mental illness.

In comparing the sociological model (see below) with the medical model, three implications of the latter are important. First, the concept of underlying disease malfunction is critical. Behavioral actions are "symptoms"; that is, they are merely indications of the underlying pathology which is rooted in the physiological or in the psychological system. Persons cannot respond to treatment unless the diseased entity is itself treated. Second, the current situational context of the individual is not considered. Since the illness is conceptualized as stemming from malfunction within biological or psych-

logical levels, social context makes little difference. Third, the individual is seen as the locus of causation. In contrast, the sociological model views the individual's behavior as a manifestation of contemporary systemic characteristics rather than individualized internal states.

The Social Causation Hypothesis: The social causation hypothesis is derived from the sociological paradigm which assumes that individual behavior is best explained by variations in societal variables. Rather than focusing upon personality malfunction within the individual, the sociological perspective emphasizes the importance of the social environment of which individuals are an element. Durkheim suggested (Simpson, 1963) that characteristics of cultural systems could explain deviant patterns of behavior. Defining anomie as a lack or correspondence between collective goals and the opportunity for attaining them, he demonstrated that national suicide rates varied directly with levels of anomie. Building upon Durkheim's explanation of variability in suicide rates across nation states, Merton (1957) contends that deviant behavior patterns are best explained by strain within the normative system. Merton argues that there are several modes of adaptation to anomic situations (see Table 1). All but conformity constitute forms of deviant behavior. Any of these may be labeled mental illness depending upon the cultural values and ideologies present at the time. Merton emphasizes that strains (incompatabilities) within the normative structure are responsible for deviant behavior patterns.

Each social class has varying degrees of access to the

TABLE 1: A TYPOLOGY OF MODES OF INDIVIDUAL ADAPTATION

Modes of Adaptation	Cultural Goals	Institutionalized Means of Attaining Them
1. Conformity	+	+
2. Innovation	+	-
3. Ritualism	-	+
4. Retreatism	-	-
5. Rebellion	±	±

\+ acceptance of - rejection of (Merton, 1957: 140)

institutionalized means of upward social mobility; the lowest class undoubtedly has the least. Thus, normative strain may be a persistent element of lower class life, and, consequently, lower class individuals must develop some mode of adaptation to this normative incompatability.

> Lacking sufficient power and status the lower strata are unable to utilize opportunities that might otherwise be available to them. Their only recourse, it would seem, is some form of the behavior which has come to be identified as pathological, deviant or disorganized. (Roach, 1969: 300)

Epidemiological studies have demonstrated that the highest rates of most deviant behavior are found in the lowest classes. Crime rates, drug use rates, divorce and separation rates, alcholism rates, etc. are typically higher among the lower classes than among the higher classes (Roach et al, 1969: 399-503). One explanation of these higher rates of deviant behavior in the lower social classes is the normative incompatability between the success ethic and the realistic opportunities for upward social mobility available to the members of these classes.

At the highest level of abstraction this study is an investigation of deviance as a mode of adaptation to normative strain. The social causation hypothesis suggested that deviance

will co-vary with the intensity of normative strain within varying system levels, e.g., society and community. The social drift hypothesis suggested that strain levels within the societal or community system will not explain variation in deviance rates. However, only one type of deviance was selected for study, i.e., mental impairment. The basic research question was then: which of these two alternative interpretations would best account for the variation in mental impairment rates found across social class groupings.

RESEARCH DESIGN

Dohrenwend and Dohrenwend (1969) developed a research design whereby this question could be pursued far more rigorously than had been done in the past. Essentially their design requires a comparison of the rates of impairment for advantaged and disadvantaged ethnic groups (with social class held constant).* In this design, normative strain refers to the inconsistency between the universal goal of upward social mobility and the downward social pressure which is experienced by the members of disadvantaged ethnic groups. Three assumptions were made regarding the relationships between mobility, ethnicity, and psychological disorder:

1. There is an almost universally shared norm in our society that upward social mobility is desirable.

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*Testing these hypotheses with samples of individuals from New York City, the Dohrenwends conceptualized the Irish, Italians and Jews as relatively advantaged ethnic groups, while Blacks and Puerto Ricans were conceptualized as relatively disadvantaged.

2. Serious psychological disorder involves disability that decreases the probability of upward social mobility and increases the probability of downward social mobility.

3. There is greater downward social pressure on Negro and Puerto Rican New Yorkers than on their class counterparts in the more advantaged ethnic groups in New York City. (1969: 52-3)

Dohrenwend and Dohrenwend suggested that the social causation hypothesis would be supported if disadvantaged ethnic groups had higher rates of impairment than their class counterparts in the more advantaged ethnic groups. The social drift hypothesis would be supported if the disadvantaged ethnic groups had lower rates of impairment than their class counterparts in the more advantaged ethnic groups. These predictions are summarized in Table 2.

The social causation hypothesis would be supported if the disadvantaged ethnic groups had higher rates of impairment because the greater downward social pressure would operate to produce mental impairment in the previously healthy members of the disadvantaged ethnic groups. Downward social pressure is conceptualized as incompatible with the goal of upward social mobility; mental impairment is viewed as a means of coping with this incompatability. Since there is less downward social pressure on advantaged ethnic groups, their members should not become mentally impaired in response to normative strain.

The social drift hypothesis would be supported if advantaged ethnic groups had higher rates of impairment because their healthy members should experience upward social mobility, leaving a concentration of the mentally impaired in the lower classes. Healthy

TABLE 2: HYPOTHETICAL SUPPORT FOR THE SOCIAL CAUSATION HYPOTHESIS VERSUS THE SOCIAL DRIFT HYPOTHESIS IN RELATIVE RATES OF DISORDER ACCORDING TO CLASS AND ETHNIC STATUS

(1=lowest rate of disorder; 4=highest rate)

CLASS STATUS	ETHNIC GROUP STATUS	
	Advantaged	Disadvantaged
	Support for Social Drift Hypothesis	
Higher	2	1
Lower	4	3
	Support for Social Causation Hypothesis	
Higher	1	2
Lower	3	4

(adapted from Dohrenwend and Dohrenwend, 1969: 56)

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members of the disadvantaged ethnic groups would not be as likely to experience upward social mobility because of the downward social pressure upon their members; thus, their rates of impairment would be diluted by their healthy members.

Research Specifics

Sample: In 1965 the Office of Economic Opportunity sponsored a research project in the low income areas of Topeka, Kansas; the questionnaire used in this research was designed to tap the "needs, problems, aspirations, and opinions" (OEO, 1966: 1) of the low income respondents. The sample was selected randomly from city blocks which met two of the following criteria:

1. More than 50% of the houses either dilapidated or deteriorated.
2. Average rent of dwelling unit less than $60.00/month.
3. Average house value less than $6,000.00. (OEO, 1966: 8)

Thirty-one percent of the designated sample was never contacted (after three call backs), indicating that the sample probably under-represented employed single persons and couples of which both members were employed. The data presented in this paper were derived from an analysis of the completed questionnaires of 680 respondents who participated in the OEO survey.

Mental Impairment: Mental impairment was assessed by responses to nineteen of the twenty-two items on the Symptom Checklist devised as part of the Midtown Manhatten Home Survey (Langer, 1962; Srole, et al, 1962). The scale is composed of psycho-physiological complaint type symptoms, many taken from the Army's Neuropsychiatric Screening Adjunct and the Minnesota Multiphasic Personality Inventory. Langer (1962) demonstrated that the 22 items could discriminate between two known groups.

> A "known well" group of 72 persons was selected from a large group by half-hour face-to-face interviews conducted by a psychiatrist. A "known ill" group was composed of 139 hospitalized and outpatient psychiatric patients. (1962: 270)

Langer established the cutting point of four symptoms as useful in distinguishing between the "well" and the "impaired".*

Ninty-nine percent of the respondents classified as well by the psychiatrists received a score of three or less on the Symptom Checklist while eighty-four percent of the incapacitated received a score of four or more. (Langer, 1962: 275) A copy of the scale used in this research is attached an an appendix at the end of the paper; a score of 4 or more was used as a cutting point

*The cutting point of 4 was established by an analysis of the Midtown Manhatten Home Survey respondents, not by an analysis of the known groups used to validate scale items.

to distinguish between the mentally impaired and the mentally healthy. (See Langer, 1965; Manis, et al, 1963, 1964 for further discussion of the validity of this scale.)

Social Class: Education of household head was used as an indicant of social class in this research; it is highly correlated with other indices of social class (see Freeman and Lambert, 1964; Kahl and Davis, 1955) and therefore, it undoubtedly taps one of the dimensions which differentiate the various social class life styles. It was chosen as the best indicant in this research because occupational and income data were not available for all respondents. Four classes were identified based upon the following cutting points:

Years Education	Label	Percent Sample
0-8	Lowest Class (I)	32% (N=219)
9-11	Blue Collar Class (II)	24% (N=166)
12	Lower Middle Class (III)	34% (N=229)
13+	Middle Class (IV)	10% (N= 66)

Ethnic Group Status: There are two sizable minority groups in Topeka, Blacks and Chicanos; these groups were conceptualized as relatively disadvantaged in comparsion with the white majority who were thought of as relatively advantaged. Sixty three percent (N=437) of the sample were classified as advantaged while 37% (N=243) were classified as disadvantaged.

RESULTS AND DISCUSSION

Other community studies (e.g., Gurin, et al, 1960; Leighton, et al, 1963, Srole, et al, 1962) have demonstrated an inverse relationship between social class and rates of mental impairment. Using education as a measure of social class, the results of this study supported these previous findings (See Table 3).

TABLE 3: RELATIONSHIP BETWEEN SOCIAL CLASS AND MENTAL IMPAIRMENT

SOCIAL CLASS	IMPAIRMENT STATUS		
	Impaired	Non-Impaired	
I (Lowest)	30% (65)	70% (154)	100% (219)
II	24% (40)	76% (126)	100% (166)
III	14% (32)	86% (197)	100% (229)
IV (Highest)	16% (11)	84% (55)	100% (66)
Total	22% (148)	87% (532)	100% (680)

$\chi^2 = 24.68$ df=3 $p < .10$

Other researchers have used different indicants of social class; yet, the results are remarkable consistent. For example, Srole, et al (1962) used a composite measure of social class (education, occupation, total family income, and rent); they found that 12.5% of the highest socioeconomic stratum could be classified as impaired compared to 47.3% of the lowest stratum (1962). While the variation found by Srole, et al was larger than that found in this study the shape of the relationship is the same.

The research design used to test the relative power of the social drift vs. the social causation hypothesis is based upon a comparison of the rates of mental impairment for the advantaged (white) and disadvantaged (Black and Chicano) ethnic groups. The social causation hypothesis suggested that the disadvantaged ethnic groups would have higher rates of mental impairment than the advantaged ethnic groups, when social class was held constant, because of the greater intensity of normative strain produced by the incompatability between downward social pressure and the desired goal of upward social mobility. The social drift

hypothesis suggested that the advantaged ethnic group would have a higher rate of mental impairment when social class was controlled; this would occur because the upward social mobility of the healthy members would result in a concentration of the mentally impaired in the lower social classes.

The results of this comparison were inconclusive, supporting neither the social drift nor the social causation hypothesis. There was no statistically significant difference between the rates of impairment for the advantaged and disadvantaged ethnic groups; neither the overall analysis nor the within class analyses indicated a relationship between ethnic status and mental impairment (see Table 4). Additionally, seventy-six within class comparisons were made in which the conditions of sex, marital status, age, and self-reported physical health were controlled. Of these seventy-six further comparisons, only seven (9%) indicated that there was a statistical difference between the rates of impairment for advantaged and disadvantaged ethnic groups;* this is slightly less than would be expected by chance alone (α =.10 in all comparisons). In each of these seven cases, however, the difference favored the social drift hypothesis. That is, the advantaged ethnic groups displayed a higher rate of impairment than the disadvantaged ethnic groups.

The Dohrenwends in a test of their own design also found the results to be inconclusive. The rates of impairment for

*Lowest class (I) in good health; lowest class in fair health; lowest class in excellent and good health; lowest class married; blue collar class (II) in fair health; blue collar class in fair and poor health; blue collar class between the ages of 41-60.

TABLE 4: RELATIONSHIPS BETWEEN ETHNIC STATUS AND MENTAL IMPAIRMENT WITH SOCIAL CLASS HELD CONSTANT

(%=percent impaired; N=total cell size, both impaired and non-impaired)

SOCIAL CLASS	ETHNIC STATUS		Chi-Square*	
	Advantaged	Disadvantaged		
I (Lowest)	32% (140)	25% (79)	0.91	NS $p > .10$
II	29% (90)	18% (76)	2.13	NS $p > .10$
III	14% (168)	13% (61)	0.18	NS $p > .10$
IV (Highest)	15% (39)	19% (27)	0.47	NS $p > .10$
Across Class	23% (437)	19% (243)	1.00	NS $p > .10$

*df=1 in all tests

Blacks were lower than the rates of impairment for the advantaged ethnic groups (Irish, Italians, Jews); this supported the social drift hypothesis; the rates for Puerto Ricans, however, were higher than those of the relatively advantaged ethnic groups, thus supporting the causation hypothesis. Wallace (1973) reported results which were also inconclusive. Advantaged ethnic groups displayed higher rates of impairment than the disadvantaged ethnic groups, but only in the lower occupational categories. In the higher occupational groups, there was no difference between mental impairment rates according to ethnic status ($\chi^2 = 0.31$, df=1).

While the data trends favor the social drift hypothesis, there is not sufficient variation among the rates of impairment for relatively advantaged and relatively disadvantaged ethnic groups and the results are not sufficiently consistent to permit either the acceptance of the social drift hypothesis or the rejection of the social causation hypothesis. Because of the

inconclusive nature of the empirical data, the assumptions forming the basis of the ethnic status comparison were reexamined. Dohrenwend and Dohrenwend assumed that normative strain was an objective condition of the social structure which affected all group members in a similar way. It is impossible to argue that disadvantaged ethnic group members do not experience greater downward social pressure than advantaged ethnic group members, thus disproportionately trapping the former in the lowest social classes. Greater downward social pressure presumably results in higher rates of mental impairment because there is no difference between the aspirational levels of members of the disadvantaged and advantaged ethnic groups. Thus Blacks, having less opportunity to own a sixty thousand dollar home, presumably experience greater normative strain than whites who (theoretically) have a greater opportunity to own such a home. By definition, disadvantaged ethnic groups members are exposed to a higher level of normative strain than are advantaged ethnic group members. Thus, the design does not force us to test whether there is a relationship between mental impairment and intensity of normative strain as actually perceived and experienced by the members of various ethnic groups.

It is conceivable that because of the greater downward social pressure, there are differential aspirational levels across ethnic groups. One mode of adaptation to anomie (see Table 1, p. 5) is ritualism whereby the individual accepts the institutionalized means of attaining his <u>individual goals</u> (rather than the culturally given goals). Given a possible re-definition of goals, disadvantaged ethnic group members may not experience a greater intensity

of normative strain; thus they would not be expected to have higher rates of mental impairment.

This, of course, is an empirical question. It hinges on two propositions. First, that there are differential interpretations of cultural goals. Thus, everyone may desire upward social mobility; however, the criteria of what constitute upward mobility, the criteria of success, may not be uniform. For example, Richard Wright in his autobiographical novel, Black Boy, states:

> I had sense enough not to hope to get rich; even to my naive imagination that possibility was too remote. I knew I lived in a country in which the aspirations of black people were limited, marked-off. Yet I felt that I had to go somewhere and do something to redeem my being alive. (1937: 186)

Second, subjectively defined intensity of normative strain is viewed as a more important etiological variable than objectively defined conditions of the social structure, although these two variables are probably inter-related. Using the discrepency between "Where I Am" and "Where I Want To Be" as a crude measure of perceived normative strain, the lack of statistical significance between the rates of mental impairment for the disadvantaged and advantaged ethnic groups may be explained by the lack of differential intensities of normative strain experienced by members of these groups.

Tentative support for this interpretation was suggested by Key (1967). Using the Kilpatrick-Cantrill Ladder (1960) he assessed the aspirations of a sample of relocated persons (both voluntary and involuntary relocators). The Kilpatrick-Cantrill Ladder is a self-anchoring scale which asks respondents to describe the best life and the worst life they can imagine.

These descriptions forms the extreme points of the 10 point ladder scale. The respondent is then asked where he would place himself on this scale. This procedure provided an opportunity to assess the perceived discrepency between "Where I Am" and "Where I Want To Be". For whites, the mean ladder position ("Where I Am") was 6.28 compared to the mean position for Blacks, Chicanos, and other minority groups of 6.07 (Key, 1937: 209). For both groups a score of 10 was the measure of "Where I Want To Be". This yielded an average discrepency between present position and aspiration of 3.93 for the disadvantaged ethnic groups and 3.72 for the advantaged ethnic groups. Although the disadvantaged ethnic groups displayed a greater discrepency, indicating a greater intensity of normative strain, the difference (0.21) was sufficiently small, that it is unlikely that it could produce much variation in mental impairment rates, especially when impairment is measured by a symptom scale.

The results of this study suggest several directions for future research on the relationship between the intensity of normative strain and rates of mental impairment. First, how can individually perceived normative strain be measured? The possible social desirability of responses to the Kilpatrick-Cantrill Ladder may seriously impair its ability to discriminate even nominally between those who perceive limited opportunities for goal achievement and those who perceive greater success potentials. Second, in conjunction with establishing a measure of normative strain, future researchers may want to devote some effort to ascertaining differential aspirational levels for various status

groups in American society. How do individuals define the "good life"? Does this definition vary according to ethnicity, sex, age, religion, physical health, etc.? Third, does objectively defined normative strain vary with subjectively perceived normative strain? Does greater downward social pressure result in a re-definition of cultural goals so that these goals are realistically attainable? Fourth, what is the relationship (if any) between the self-perceived discrepency between "Where I Am" and "Where I Want To Be" and various types of deviance? Do those groups of people with a greater discrepency also tend to display higher rates of deviance in general or mental impairment in particular?

Summary

This research explored the etiological issue revolving around the concentration of the mentally impaired in the lower social classes. The design employed to test the relative explanatory power of the social causation vs. the social drift hypotheses failed to take into account the possibility that persons who objectively have little opportunity for upward social mobility may not perceive their limited opportunities or may not desire the same degree of upward mobility as those persons who objectively have more opportunity to attain it. Thus, the etiological issue has not been resolved; the data do not consistently demonstrate support for the social causation or the social drift hypothesis.

APPENDIX: MENTAL IMPAIRMENT SCALE*

1. Have you ever been bothered by your heart beating hard? Would you say:
   1--often 2--sometimes 3--never
2. Have you ever been bothered by shortness of breath when you were not working hard? Would you say:
   1--often 2--sometimes 3--never
3. Have you ever had any fainting spells? (Lost consciousness) Would you say:
   1--never 2--a few times 3--more than a few times
4. Would you say your appetite is:
   1--poor 2--fair 3--good 4--too good
5. Do you ever have any trouble getting to sleep or staying asleep? Would you say:
   1--often 2--sometimes 3--never
6. Are you the worrying type? 1--no 2--yes
7. Have you ever been bothered by "cold sweats"? Would you say:
   1--often 2--sometimes 3--never
8. Are you ever bothered by nervousness (irritable, fidgety, tense)? Would you say:
   1--often 2--sometimes 3--never
9. Are you ever troubled with headaches or pains in the head? Would you say:
   1--often 2--sometimes 3--never
10. Do your hands ever tremble enough to bother you? Would you say:
    1--often 2--sometimes 3--never
11. My memory seems to be good. 1--yes 2--no
12. I feel weak all over much of the time. 1--yes 2--no
13. I have periods of days, weeks, or months when I couldn't take care of things because I couldn't get going.
    1--yes 2--no
14. In general would you say that most of the time you are in:
    1--very good spirits 2--good spirits
    3--low spirits 4--very low spirits
15. I am bothered by acid (sour) stomach several times a week.
    1--yes 2--no
16. There seems to be a fullness (clogging) in my head much of the time. 1--yes 2--no
17. I have personal worries that get me down physically.
    1--yes 2--no
18. Every so often I suddenly feel hot all over. 1--yes 2--no
19. I have periods of such great restlessness that I cannot sit still very long. 1--yes 2--no.

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*Impaired response is underlined.

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